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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10

CERTIFICATE OF DEATH

DATE

NAME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PLACE OF BIRTH

PLACE OF DEATH

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5652 CERTIFICATE OF DEATH

05647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
c. LENGTH OF STAY IN 1b <u>15 Yrs.</u>		d. STREET ADDRESS <u>Dallam Place</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dallam Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ayres</u>		4. DATE OF DEATH Month Day Year <u>May 30 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 6, 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Mc Kee</u>	
14. MOTHER'S MAIDEN NAME <u>Wann</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mary c. Ayres</u> Address <u>Dallam Place, Bel Air, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Cardio-Vascular Disease</u> DUE TO (c) <u>10 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 2, 1953</u> , to <u>May 30, 1959</u> , that I last saw the deceased alive on <u>May 30, 1959</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Md.</u>		DATE SIGNED <u>May 30, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson M.D.</u>		<u>Forest Hill, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>June 3, 1959</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius</u>	22d. LOCATION (City, town, or county) (State) <u>Hickory, Harford Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Inter</u> ADDRESS <u>W. Broadway + Williams St. Bel Air, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

1000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan. 15, 1890</u></p>		<p>4. Place of birth: <u>St. Louis, Mo.</u></p>	
<p>5. Date of death: <u>Dec. 10, 1945</u></p>		<p>6. Place of death: <u>St. Louis, Mo.</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Immediate cause: <u>Myocardial infarction</u></p>	
<p>9. Duration of illness: <u>2 weeks</u></p>		<p>10. Usual place of abode: <u>St. Louis, Mo.</u></p>	
<p>11. Name of physician: <u>Dr. J. H. Smith</u></p>		<p>12. Name of funeral home: <u>None</u></p>	
<p>13. Name of informant: <u>John J. Smith</u></p>		<p>14. Name of informant: <u>John J. Smith</u></p>	
<p>15. Name of informant: <u>John J. Smith</u></p>		<p>16. Name of informant: <u>John J. Smith</u></p>	
<p>17. Name of informant: <u>John J. Smith</u></p>		<p>18. Name of informant: <u>John J. Smith</u></p>	
<p>19. Name of informant: <u>John J. Smith</u></p>		<p>20. Name of informant: <u>John J. Smith</u></p>	
<p>21. Name of informant: <u>John J. Smith</u></p>		<p>22. Name of informant: <u>John J. Smith</u></p>	
<p>23. Name of informant: <u>John J. Smith</u></p>		<p>24. Name of informant: <u>John J. Smith</u></p>	
<p>25. Name of informant: <u>John J. Smith</u></p>		<p>26. Name of informant: <u>John J. Smith</u></p>	
<p>27. Name of informant: <u>John J. Smith</u></p>		<p>28. Name of informant: <u>John J. Smith</u></p>	
<p>29. Name of informant: <u>John J. Smith</u></p>		<p>30. Name of informant: <u>John J. Smith</u></p>	
<p>31. Name of informant: <u>John J. Smith</u></p>		<p>32. Name of informant: <u>John J. Smith</u></p>	
<p>33. Name of informant: <u>John J. Smith</u></p>		<p>34. Name of informant: <u>John J. Smith</u></p>	
<p>35. Name of informant: <u>John J. Smith</u></p>		<p>36. Name of informant: <u>John J. Smith</u></p>	
<p>37. Name of informant: <u>John J. Smith</u></p>		<p>38. Name of informant: <u>John J. Smith</u></p>	
<p>39. Name of informant: <u>John J. Smith</u></p>		<p>40. Name of informant: <u>John J. Smith</u></p>	
<p>41. Name of informant: <u>John J. Smith</u></p>		<p>42. Name of informant: <u>John J. Smith</u></p>	
<p>43. Name of informant: <u>John J. Smith</u></p>		<p>44. Name of informant: <u>John J. Smith</u></p>	
<p>45. Name of informant: <u>John J. Smith</u></p>		<p>46. Name of informant: <u>John J. Smith</u></p>	
<p>47. Name of informant: <u>John J. Smith</u></p>		<p>48. Name of informant: <u>John J. Smith</u></p>	
<p>49. Name of informant: <u>John J. Smith</u></p>		<p>50. Name of informant: <u>John J. Smith</u></p>	
<p>51. Name of informant: <u>John J. Smith</u></p>		<p>52. Name of informant: <u>John J. Smith</u></p>	
<p>53. Name of informant: <u>John J. Smith</u></p>		<p>54. Name of informant: <u>John J. Smith</u></p>	
<p>55. Name of informant: <u>John J. Smith</u></p>		<p>56. Name of informant: <u>John J. Smith</u></p>	
<p>57. Name of informant: <u>John J. Smith</u></p>		<p>58. Name of informant: <u>John J. Smith</u></p>	
<p>59. Name of informant: <u>John J. Smith</u></p>		<p>60. Name of informant: <u>John J. Smith</u></p>	
<p>61. Name of informant: <u>John J. Smith</u></p>		<p>62. Name of informant: <u>John J. Smith</u></p>	
<p>63. Name of informant: <u>John J. Smith</u></p>		<p>64. Name of informant: <u>John J. Smith</u></p>	
<p>65. Name of informant: <u>John J. Smith</u></p>		<p>66. Name of informant: <u>John J. Smith</u></p>	
<p>67. Name of informant: <u>John J. Smith</u></p>		<p>68. Name of informant: <u>John J. Smith</u></p>	
<p>69. Name of informant: <u>John J. Smith</u></p>		<p>70. Name of informant: <u>John J. Smith</u></p>	
<p>71. Name of informant: <u>John J. Smith</u></p>		<p>72. Name of informant: <u>John J. Smith</u></p>	
<p>73. Name of informant: <u>John J. Smith</u></p>		<p>74. Name of informant: <u>John J. Smith</u></p>	
<p>75. Name of informant: <u>John J. Smith</u></p>		<p>76. Name of informant: <u>John J. Smith</u></p>	
<p>77. Name of informant: <u>John J. Smith</u></p>		<p>78. Name of informant: <u>John J. Smith</u></p>	
<p>79. Name of informant: <u>John J. Smith</u></p>		<p>80. Name of informant: <u>John J. Smith</u></p>	
<p>81. Name of informant: <u>John J. Smith</u></p>		<p>82. Name of informant: <u>John J. Smith</u></p>	
<p>83. Name of informant: <u>John J. Smith</u></p>		<p>84. Name of informant: <u>John J. Smith</u></p>	
<p>85. Name of informant: <u>John J. Smith</u></p>		<p>86. Name of informant: <u>John J. Smith</u></p>	
<p>87. Name of informant: <u>John J. Smith</u></p>		<p>88. Name of informant: <u>John J. Smith</u></p>	
<p>89. Name of informant: <u>John J. Smith</u></p>		<p>90. Name of informant: <u>John J. Smith</u></p>	
<p>91. Name of informant: <u>John J. Smith</u></p>		<p>92. Name of informant: <u>John J. Smith</u></p>	
<p>93. Name of informant: <u>John J. Smith</u></p>		<p>94. Name of informant: <u>John J. Smith</u></p>	
<p>95. Name of informant: <u>John J. Smith</u></p>		<p>96. Name of informant: <u>John J. Smith</u></p>	
<p>97. Name of informant: <u>John J. Smith</u></p>		<p>98. Name of informant: <u>John J. Smith</u></p>	
<p>99. Name of informant: <u>John J. Smith</u></p>		<p>100. Name of informant: <u>John J. Smith</u></p>	

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5672 CERTIFICATE OF DEATH

05648

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norrisville		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Nicholas N. Ayres		4. DATE OF DEATH Month Day Year May 9 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1876
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer retired		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Shawsville, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Ayres		14. MOTHER'S MAIDEN NAME Alice Ann Norris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 205-22-3834A	
17. INFORMANT Arnold Ayres		Address Fawn Grove, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis, hypertensive 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to infirmities of old age. DUE TO (c) generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 19, 1959 to May 9, 1959 , that I last saw the deceased alive on May 7, 1959 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stewartstown, Pa. May 9, 1959.			
ACTUAL SIGNATURE Norman H. Gemmill		M.D. Stewartstown, Pa.	
PHYSICIAN'S NAME (Type) Norman H. Gemmill			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/11/1959	
22c. NAME OF CEMETERY OR CREMATORY Ayres Chapel		22d. LOCATION (City, town, or county) (State) White Hall, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hurt		ADDRESS Stewartstown, Md.	
24a. REC'D BY REGISTRAR MAY 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

15589

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>	
<p>2. Date of death: <u>10/15/57</u></p>	
<p>3. Place of death: <u>Home</u></p>	
<p>4. Age at death: <u>68</u></p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Marital status: <u>Married</u></p>	
<p>8. Occupation: <u>Retired</u></p>	
<p>9. Cause of death: <u>Heart Disease</u></p>	
<p>10. Immediate cause: <u>Myocardial Infarction</u></p>	
<p>11. Underlying cause: <u>Coronary Artery Disease</u></p>	
<p>12. Contributing cause: <u>None</u></p>	
<p>13. Manner of death: <u>Natural</u></p>	
<p>14. Signature of physician: <u>[Signature]</u></p>	
<p>15. Signature of registrar: <u>[Signature]</u></p>	

1. This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

2. A copy of this certificate is to be sent to the local health officer of the jurisdiction in which the death occurred.

3. A copy of this certificate is to be sent to the local health officer of the jurisdiction in which the death occurred.

4. A copy of this certificate is to be sent to the local health officer of the jurisdiction in which the death occurred.

5. A copy of this certificate is to be sent to the local health officer of the jurisdiction in which the death occurred.

3653. CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN lb <u>5 mos.,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>L.</u> Last <u>Bowers</u>			4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 13, 1916</u>		9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Guy M. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude S. Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Ruth P. Taylor, Bel Air, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESP. FAILURE</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC CARCINOMA.</u> DUE TO (c) <u>CARCINOMA OF BREAST</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>4 hrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 MARCH</u> 19 <u>59</u> , to <u>9 MAY</u> 19 <u>59</u> , that I last saw the deceased alive on <u>5 MAY</u> 19 <u>59</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.P. Sidwell</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>401 Franklin St., Bel Air, Md. 11 May 59</u>			
PHYSICIAN'S NAME (Type) <u>H.P. Sidwell</u>				<u>401 Franklin St., Bel Air, Maryland.</u>			
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Md.,</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard S. Williams</u>				ADDRESS <u>Abingdon, Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 14 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
BUREAU OF CEREBRAL PALSY

NAME: _____
AGE: _____
SEX: _____
DATE OF BIRTH: _____
PLACE OF BIRTH: _____
DATE OF ADMISSION: _____
DATE OF DISCHARGE: _____
REASON FOR ADMISSION: _____
REASON FOR DISCHARGE: _____
TREATMENT: _____
PROGNOSIS: _____
REMARKS: _____

NAME: _____
AGE: _____
SEX: _____
DATE OF BIRTH: _____
PLACE OF BIRTH: _____
DATE OF ADMISSION: _____
DATE OF DISCHARGE: _____
REASON FOR ADMISSION: _____
REASON FOR DISCHARGE: _____
TREATMENT: _____
PROGNOSIS: _____
REMARKS: _____

3654 CERTIFICATE OF DEATH

05650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. LENGTH OF STAY IN 1b 21 HRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE	
3. NAME OF DECEASED (Type or print) BABY BOY BRENDLE		d. STREET ADDRESS 616 LEWIS	
4. DATE OF DEATH MAY 7 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 6, 1959
9. AGE (In years, last birthday) 20 54		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WM K. BRENDLE		14. MOTHER'S MAIDEN NAME EVELYN JANE Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Dr. WM K. BRENDLE		Address HAVRE DE GRACE, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO PULMONARY 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYALINE MEMBRANE DISEASE DUE TO (c) PREMATURITY (WEIGHT 5*5 1/2 oz)			INTERVAL BETWEEN ONSET AND DEATH 8 hrs -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 May 1959 , to 7 May 1959 , that I last saw the deceased alive on 7 May 1959 , and that death occurred at 2:35 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert Norman M.D.		DATE SIGNED 6 May 1959	
PHYSICIAN'S NAME (Type) Robert Norman M.D.		ADDRESS (Street, city or town, state) 602 1 Union Ave Havre de Grace Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-8-1959	22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL Cem	22d. LOCATION (City, town, or county) (State) HAVRE DE GRACE MD
23. FUNERAL DIRECTOR'S SIGNATURE A. Madison Mitchell		ADDRESS Havre de Grace Md.	
24a. REC'D BY REGISTRAR MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

2071353XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02650

2025 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form with multiple sections for death certificate, including fields for name, date, cause of death, and signature. The form is filled out with handwritten text, which is mostly illegible due to the quality of the scan. The form is divided into several horizontal sections by lines, with some sections containing checkboxes or specific instructions. The text is written in cursive or a similar handwritten style. The form appears to be a standard Maryland State Department of Health certificate from 1925.



Vertical text on the right margin, likely a filing or processing stamp, containing the words "RECEIVED" and "FILED".

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

Item 18, Film 5673 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05651

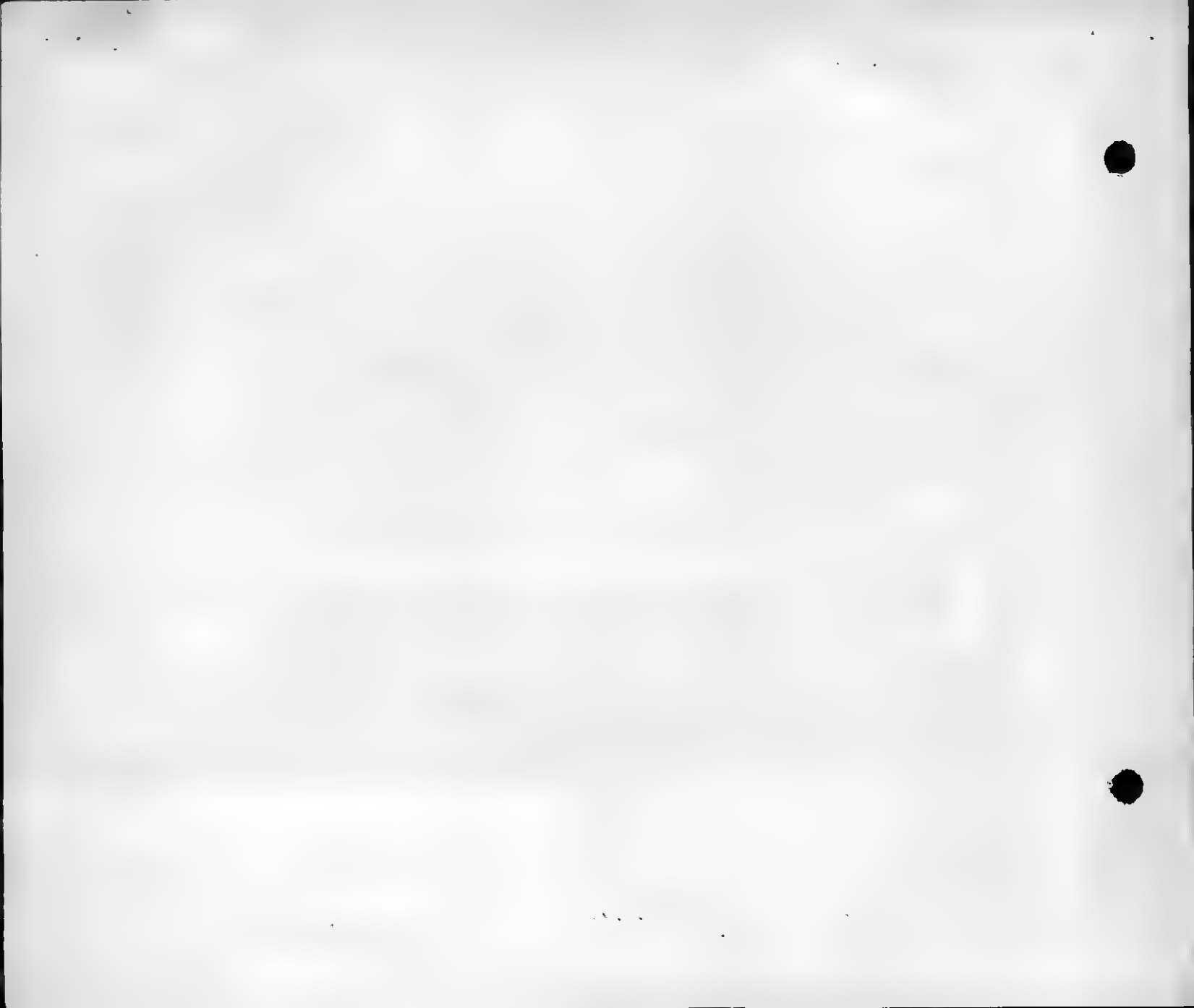
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, Md. c. LENGTH OF STAY IN 1b 2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air d. STREET ADDRESS Alliance e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FATE First Middle Last BROWN		4. DATE OF DEATH Month Day Year 5 9 1959	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/1930
9. AGE (In years, last birthday) 28 39		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Latimer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Hamletville Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Brown		14. MOTHER'S MAIDEN NAME Cassie Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W.W. 2		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT James Hill Savannah Ga.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) H1X (c) slating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin EXAMINER'S NAME (Type) PAUL F. GUERIN		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5-16-59	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5/17/59	22c. NAME OF CEMETERY OR CREMATORY Sylvester	22d. LOCATION (City, town, or county) (State) Sylvester Ga.
23. FUNERAL DIRECTOR'S SIGNATURE Conroy		24a. REC'D BY REGISTRAR DATE MAY 18 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Kenna

1

2

12



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

5674

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 1 FilmG243 5/27/59 cap

05652

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>rural Bel Air</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Private Home Graftons Road, Churchville</u>				STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>rural Jarrettsville</u> STREET ADDRESS (If rural give location) <u>Rocks, RD</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Maudie Elizabeth Brown</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 16, 1959</u>			
5. SEX <u>F</u>	6. CO. OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 22, 1890</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Renick, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harvey Brown</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Boggs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>233-34- 5252</u>		17. INFORMANT & ADDRESS <u>Isaac M. Brown Rocks, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1. IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						<u>24 days</u>	
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertensive C-V-D</u>						<u>20 years</u>	
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/28/59</u> , 19..... to <u>5/16/59</u> , 19....., that I last saw the deceased alive on <u>5/16/59</u> , 19....., and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert B. Smith</u>		M.D. <u>Forest Hill, Maryland</u>		DATE SIGNED <u>5/16/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/21/1959</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>MAY 19 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kutz</u> ADDRESS <u>Jarrettsville Md.</u>			



5675

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

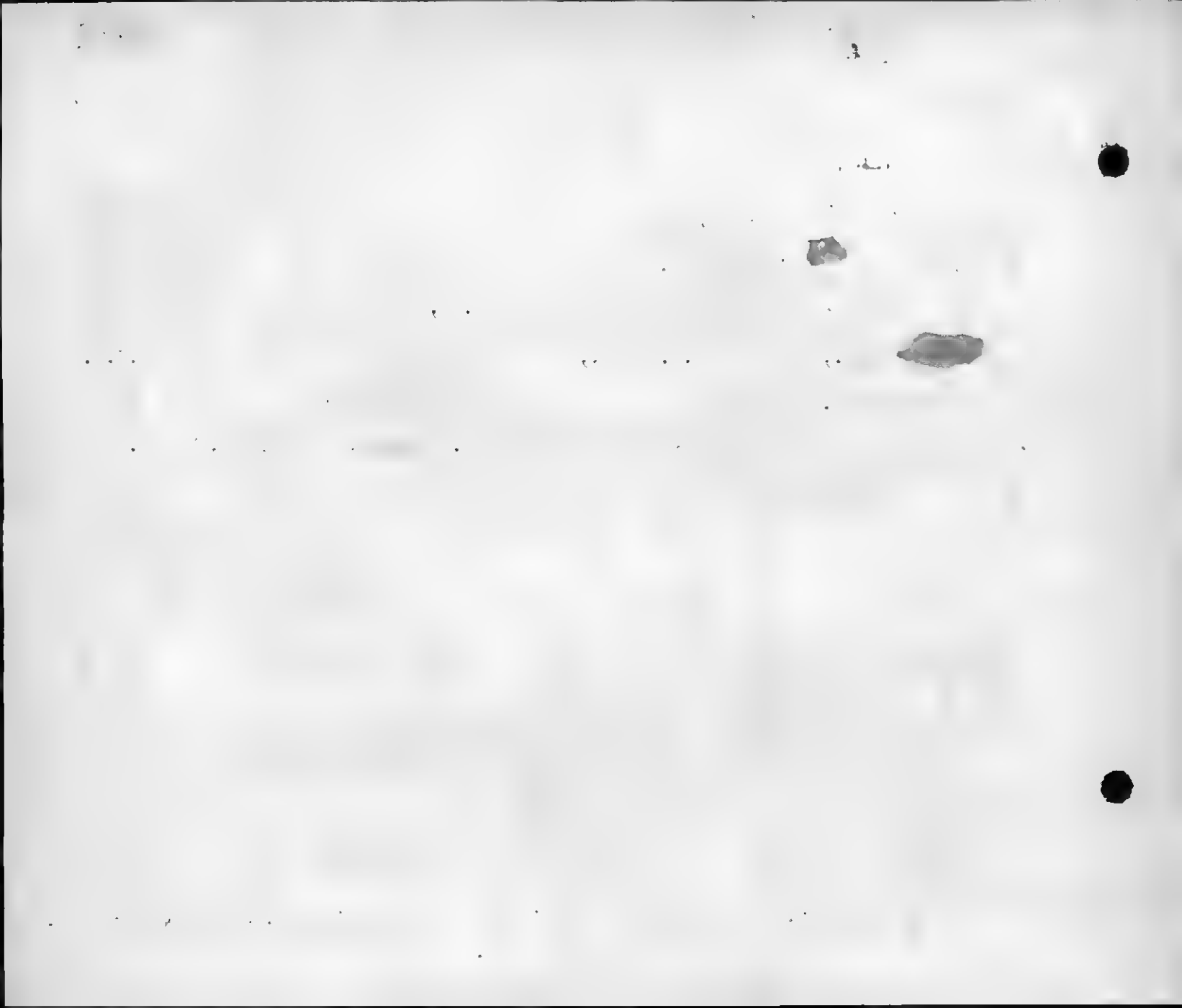
05653

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>US Route 70 40</u>		d. STREET ADDRESS <u>Custer St.</u>	
3. NAME OF DECEASED (Type or print) <u>Judy G. Burgess</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1938</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk-Steno.,</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>	9. AGE (last b. rthday) <u>20</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William R. Burgess</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Lynch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>007-38-6702</u>	
17. INFORMANT <u>William R. Burgess,</u>		Address <u>Sanford, Maine.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>5-30-59</u> Hour <u>12:15</u> a.m. <u>p.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 70</u>		20f. (City or town) (County) (State) <u>Jaffee Harford MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u> DATE SIGNED <u>5-30-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June, 3, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Fairfax, Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCon Jr</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>	
ADDRESS <u>Abingdon, Maryland.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

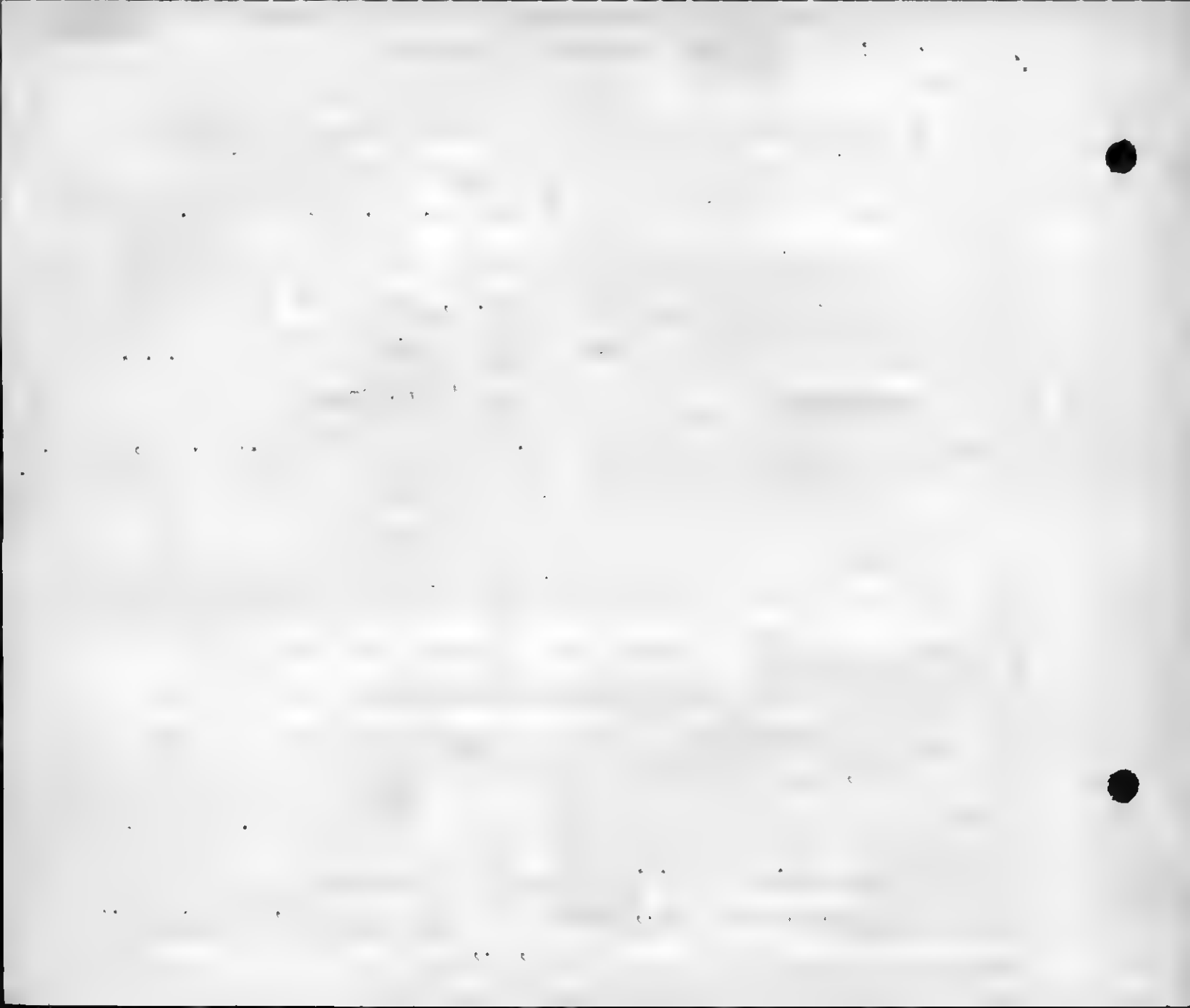
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05654

5655 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home				d. STREET ADDRESS Wheel Rd., Rt. # 2, Bel Air, Md.			
3. NAME OF DECEASED (Type or print) First Ennice Middle Cheek Last Cheek				4. DATE OF DEATH Month May Day 25 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 28, 1873	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	
10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ashley Cheek				14. MOTHER'S MAIDEN NAME Ada Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Cecil Cheek, Wheel Rd., Rt. # 1, Bel Air, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia, terminating 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic hypertensive cardio-vascular disease (c) 15 years						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Forest Hill, Md.				20g. (County) Harford		20h. (State) Md.	
21. I certify that I attended the deceased from June 1939 to May 25, 1959 , that I last saw the deceased alive on May 25, 1959 , and that death occurred at 10:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED May 25, 1959							
ACTUAL SIGNATURE Willard P. Hudson M.D.				DATE SIGNED May 25, 1959			
NAME (Type) Willard P. Hudson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 27, 1959		22c. NAME OF CEMETERY OR CREMATORY Mt., Carmel		22d. LOCATION (City, town, or county) (State) Emmorton, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Hudson				ADDRESS Abingdon, Md.		24a. REC'D BY REGISTRAR DATE JUN 1 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hudson			



FOR STATE
HEALTH DEPT.

5656

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05655

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>	
c. LENGTH OF STAY IN 1b <u>2 YRS</u>		d. STREET ADDRESS <u>12 LANGFORD PLACE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12 LANGFORD PLACE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FIRST</u> <u>THEODORE</u> <u>MIDDLE</u> <u>EUGENE</u> <u>LAST</u> <u>CORNELL</u>		4. DATE OF DEATH <u>MONTH</u> <u>MAY</u> <u>DAY</u> <u>16</u> <u>YEAR</u> <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 12, 1907</u> 9. AGE (In years last b. day) <u>51</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NAT. GAS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GAS LINES</u>	11. BIRTHPLACE (State or foreign country) <u>WEST VA.</u>
13. FATHER'S NAME <u>LAFAYETTE CORNELL</u>		14. MOTHER'S MAIDEN NAME <u>NANCY PETHTEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>233-16-5072</u>	
17. INFORMANT <u>MRS ORA CORNELL</u>		Address <u>12 LANGFORD, BEL AIR</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>ACUTE CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip W. Heuman</u>		DATE SIGNED <u>MAY 16, 1959</u>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>MAY 19, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Willow Island</u>	22d. LOCATION (City, town, or county) <u>Havreley</u> (State) <u>W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>		24a. REC'D BY REGISTRAR <u>Bellevue Md</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. File pages 1 and 2 with the State Board of Health. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. Page 5 may be retained for your files. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be completed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

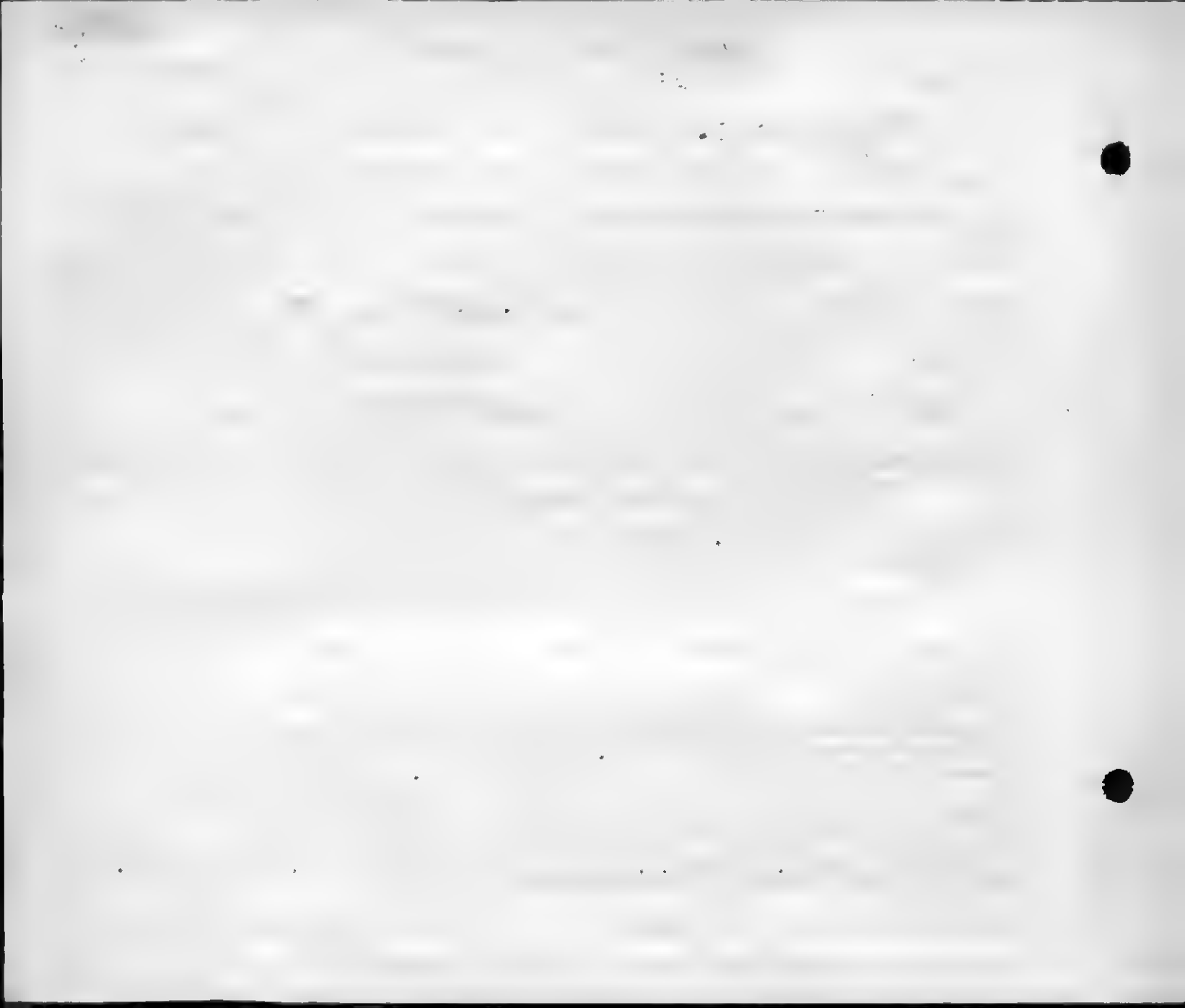
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05656

5657 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. LENGTH OF STAY IN 1b <u>7 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Almehouse- Harford County</u>				e. STREET ADDRESS <u>ALMHOUSE- HARFORD, CO.</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>LEE</u> Middle <u>Curry</u> Last				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 20, 1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>				13. FATHER'S NAME <u>John Wright</u>			
14. MOTHER'S MAIDEN NAME <u>Martha Crew</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>SAMUEL G. CURRY, HARFORD, CO., MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr. Cardio-Vascular Disease</u> DUE TO (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. ft.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Oct. 1952</u> , 19____ to <u>May 1959</u> , 19____, that I last saw the deceased alive on <u>May 29, 1959</u> , 19____, and that death occurred at <u>2 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>5/30/59</u>							
ACTUAL SIGNATURE <u>Willard P. Hudson M.D.</u>				PHYSICIAN'S NAME (Type) <u>Willard P. Hudson M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>6-1-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCKFORD CEM.</u>	
22d. LOCATION (City, town, or county) <u>HARFORD</u>				22e. (State) <u>MD.</u>		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willard P. Hudson M.D.</u>				23a. REC'D BY REGISTRAR <u>JUN 3 '59</u>		23b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



5658 CERTIFICATE OF DEATH

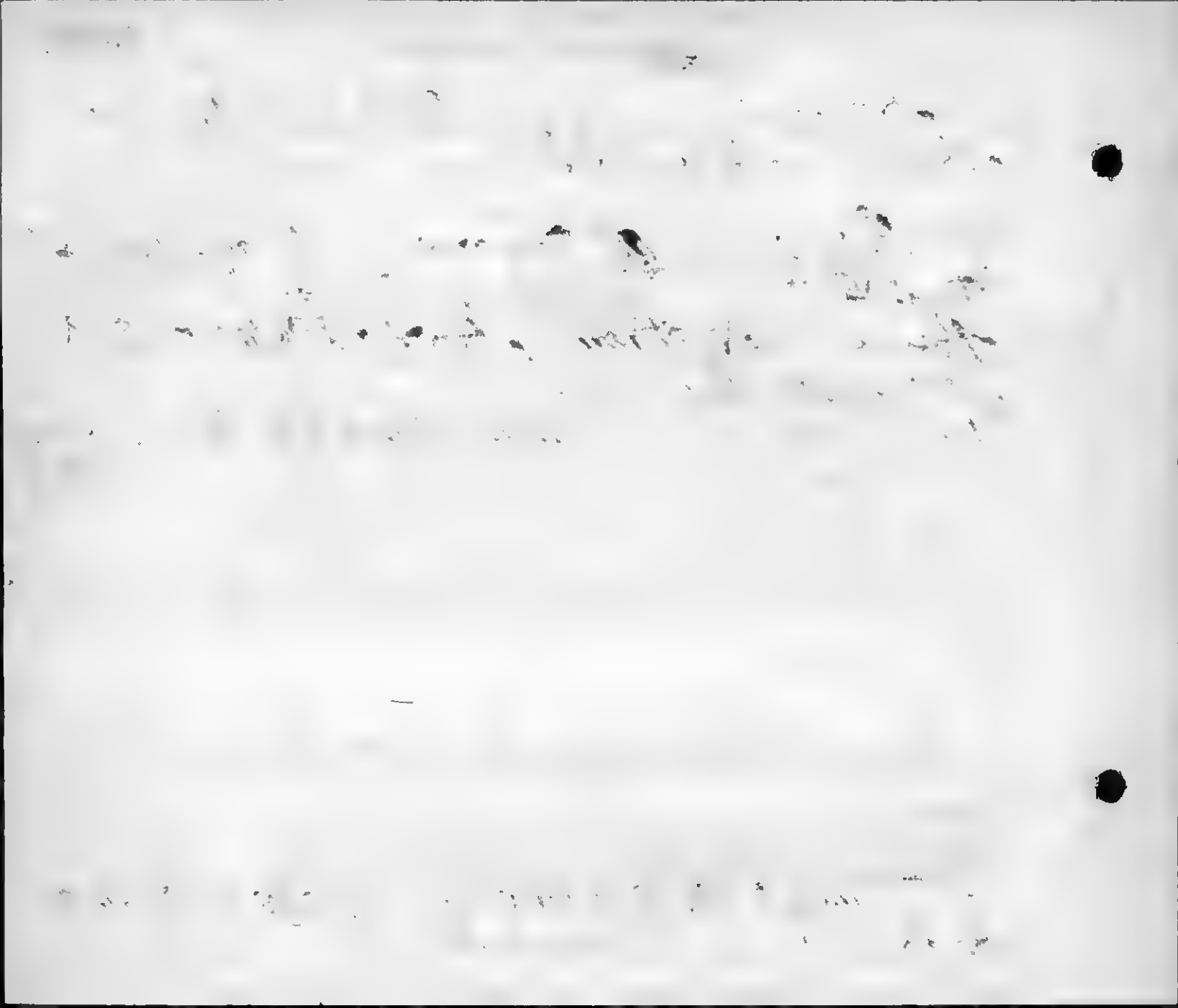
05657

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwin Bridge Rd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Eller M. Edwards</u>		4. DATE OF DEATH <u>May 22 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 21, 1871</u>
9. AGE (in years last birthday) <u>88</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u>		11. BIRTH PLACE (State or foreign country) <u>Harford Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James H. Bowman</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Sheridan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give date of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>212-14-1496B</u>		17. INFORMANT <u>Wm. Edwards</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4-2-1</u> DUE TO <u>Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 4, 1959</u> to <u>May 22, 1959</u> , that I last saw the deceased alive on <u>May 22, 1959</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F.P. Snodgrass</u>		DATE SIGNED <u>5/23/59</u>	
PHYSICIAN'S NAME (Type) <u>F.P. Snodgrass</u>			
22a. BURIAL <input checked="" type="checkbox"/> REMOVAL <input type="checkbox"/>	22b. DATE THEREOF <u>May 25, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24. REGISTRAR'S SIGNATURE <u>W. S. Bailey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1894-1904-1914-1924-1934-1944-1954-1964-1974-1984-1994-2004-2014-2024

5659

CERTIFICATE OF DEATH

Reg. Dist. No.

05658

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>1 Hr. 55 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>			
d. STREET ADDRESS <u>952 CHESAPEAKE DR.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>GRILLE</u> Last <u>GRILLE</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>2</u> Year <u>19 59</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/14/1914</u>	
9. AGE (In years last birthday) <u>45 1/2</u> yrs.		IF UNDER 1 YEAR: Months <u>4</u> Days <u>15</u> Hours <u>15</u> Min. <u>45</u>		IF UNDER 24 HRS: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FEDERAL EMPLOYEE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE BAEKEY</u>				14. MOTHER'S MAIDEN NAME <u>NELLIE BOYD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hande Shae Mc.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>7/29</u> , 19 <u>59</u> , to <u>5/2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/2</u> , 19 <u>59</u> , and that death occurred at <u>10:53</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Irwin Randall Ross</u> M.D. <u>200 N. Union Ave</u>							
PHYSICIAN'S NAME (Type) <u>IRWIN RANDALL ROSS</u> <u>Haure de Grace, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>5/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Hande Shae Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hande Shae Md</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>DATE MAY 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5676

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKS (RURAL)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKS (RURAL)</u>	
c. LENGTH OF STAY IN TB <u>3 MONTHS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHARON RD</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALFRED ANDREW GUNTENSPERGER</u>		4. DATE OF DEATH Month Day Year <u>MAY 6 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 10, 1916</u>
9. AGE (In years last birthday) <u>43</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EDGEWOOD ARSENAL</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALFRED J. GUNTENSPERGER</u>		14. MOTHER'S MAIDEN NAME <u>MARY D. ROTH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES W.W.II</u>		16. SOCIAL SECURITY NO. <u>MARY GUNTENSPERGER SAME</u>	
17. INFORMANT <u>MARY GUNTENSPERGER SAME</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1 CORONARY THROMBOSIS</u> DUE TO (b) <u>NONE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION 5-9-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEM.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Ziller</u>		24a. REC'D BY REGISTRAR <u>MAY 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles J. Ziller</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



5677 CERTIFICATE OF DEATH

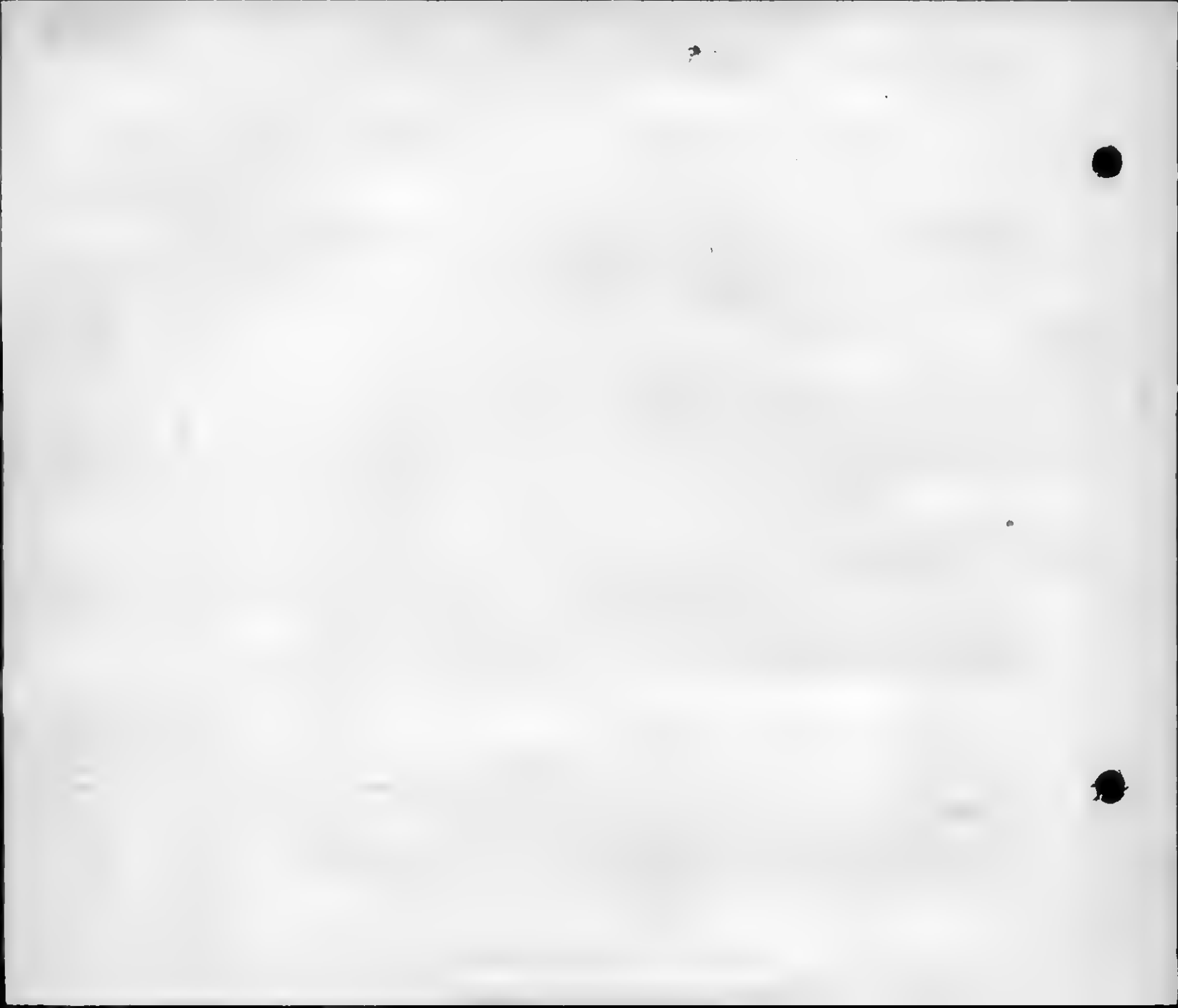
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>x darlington</u>	
3. NAME OF DECEASED (Type or print) <u>Anna J. Hopkins</u>		4. DATE OF DEATH <u>May 16 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford</u>	
11. BIRTHPLACE (State or foreign country) <u>Calmd U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Francis J. Hopkins</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Harper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) <u>No</u> (If yes, give dates of service)		16. SOCIAL SECURITY NO <u>No</u>	
17. INFORMANT <u>Miss Isabelle Brown</u>		Address <u>Darlington Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Old Age</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Old Age</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 14, 1947</u> to <u>May 16, 1959</u> , that I last saw the deceased alive on <u>May 12, 1959</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips</u> M.D.		ADDRESS (Street, city or town, state) <u>Darlington Md</u> DATE SIGNED <u>5/20/59</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>		<u>Darlington Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Buried</u>	<u>May 17, 1959</u>	<u>Darlington</u>	<u>Harford Co, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Bailey</u> ADDRESS <u>Darlington Md</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>MAY 28 '59</u>	<u>Arthur J. Henth</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 **FOR STATE HEALTH DEPT.**

5660

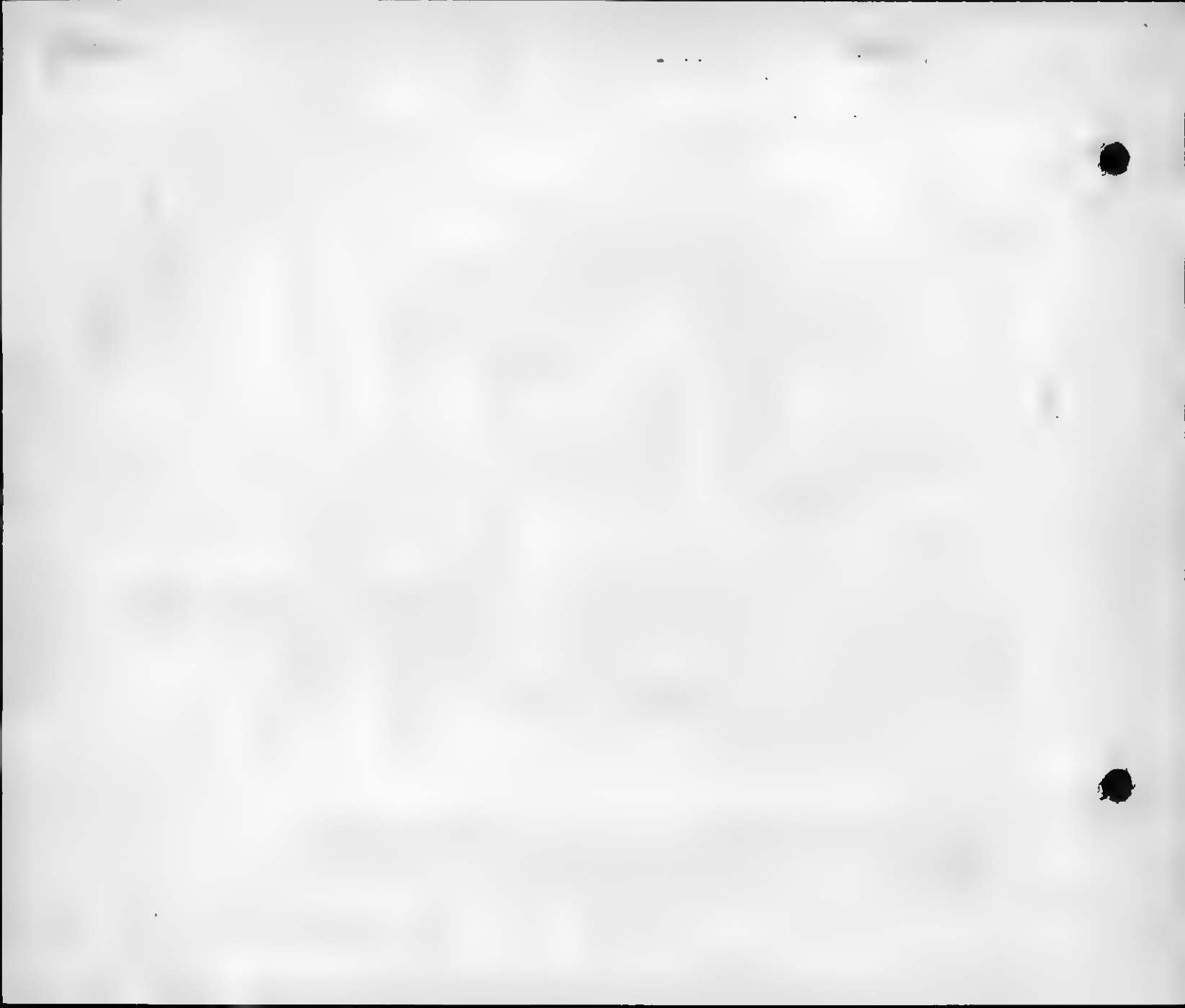
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Creek</u>		c. LENGTH OF STAY IN 1b <u>62 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Creek</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Revolution St</u>			d. STREET ADDRESS <u>111 N. Stokes St</u>		e. RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>George Warren Hughes</u> First Middle Last			4. DATE OF DEATH <u>May 28</u> 19 <u>57</u> Month Day Year		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/13/1897</u>	9. AGE (last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garage</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Harrods Creek</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>George W. Hughes Sr</u>			14. MOTHER'S MAIDEN NAME <u>Laura Anthony</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Geo. W. Hughes 111 N. Stokes</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Beltin, Md</u> DATE SIGNED		
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/31/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Harrods Creek Md</u>	
22d. LOCATION (City, town, or county) (State) <u>Harrods Creek Md</u>		22e. REC'D BY REGISTRAR JUN 3 '59		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Permyer, Harrods Creek, Md.</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57

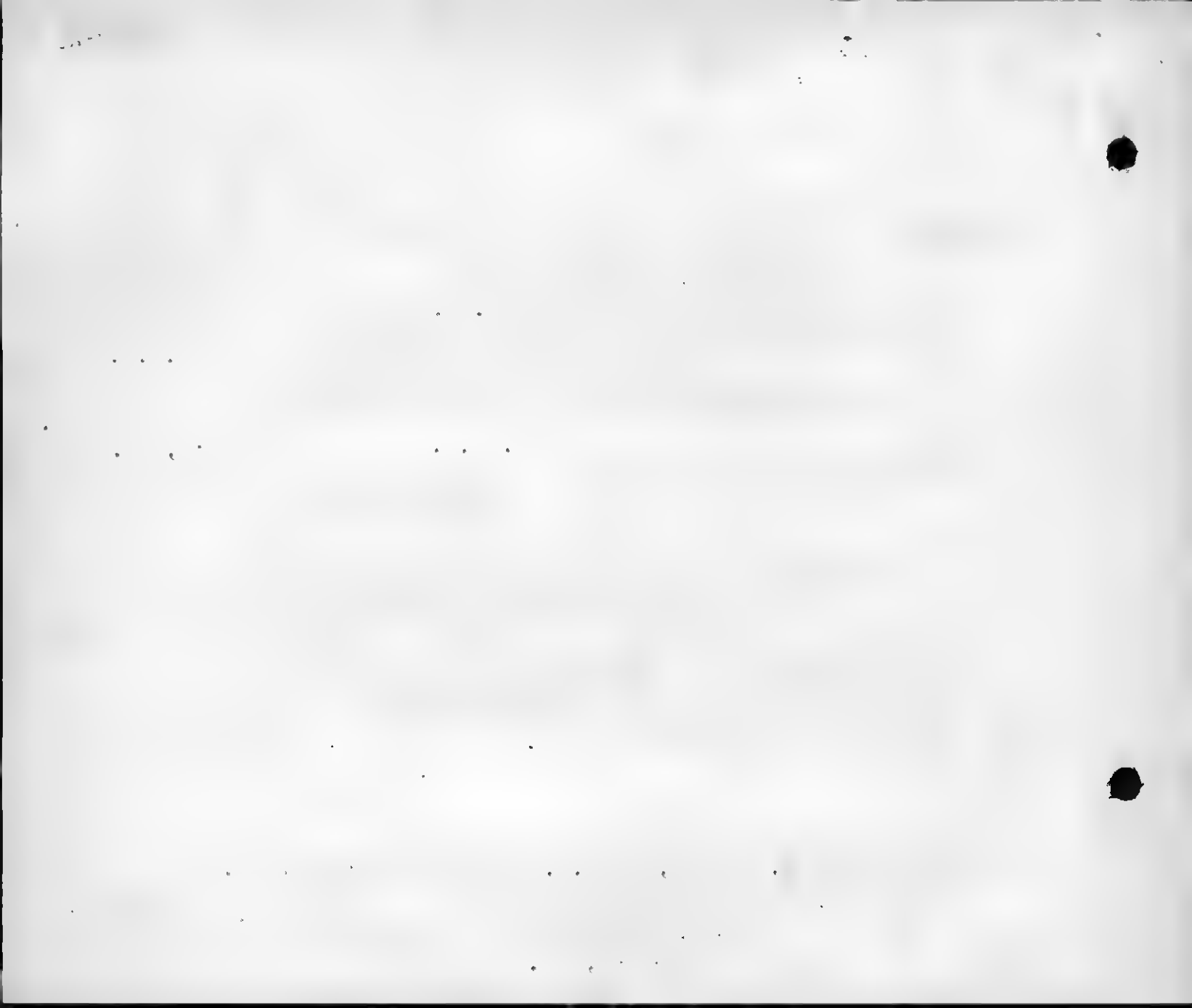
5678

CERTIFICATE OF DEATH

05662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 133 Post Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First LEWIS Middle HENRY Last MARTIN			4. DATE OF DEATH Month May Day 18 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1883		9. AGE (In years last birthday) 75 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Chapman Martin			14. MOTHER'S MAIDEN NAME Cornelia Slee		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Address 133 Post Rd. Mrs. L.H. Martin, Aberdeen, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4a. i DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Myocardial Infarction Coronary Occlusion Coronary arteriosclerosis					INTERVAL BETWEEN DEATH AND DEATH Terminal Terminal 2 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1953 , 19 5-18-1959 , that I last saw the deceased alive on 5-18-1959 , and that death occurred at 12:30 AM from the causes and on the date stated above ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED 5-18-59 ACTUAL SIGNATURE Peter P. Rodman M.D. FURNERARY DIRECTOR'S SIGNATURE Peter P. Rodman, M.D. Aberdeen, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/59		22c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery	
22d. LOCATION (City, town, or county) (State) Perryman, Maryland		24a. REC'D BY REGISTRAR DATE MAY 20 '59			
24b. REGISTRAR'S SIGNATURE Arthur L. Hines					



5661 CERTIFICATE OF DEATH

Reg. Dist. No. 05663

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>R.D. # 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Ira</u> Middle <u>Cleveland</u> Last <u>Mosemer</u>		4. DATE OF DEATH Month <u>5</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 30, 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mosemer, Eli</u>		14. MOTHER'S MAIDEN NAME <u>Ramer, Ida</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>176-01-1107</u>	
17. INFORMANT <u>Melvin Mosemer</u>		Address <u>York, Pa. 6 Summit R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>2 days</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/2</u> , 19 <u>59</u> , to <u>5/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/6</u> , 19 <u>59</u> , and that death occurred at <u>7:20 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips</u>		ADDRESS (Street, city or town, state) <u>Dudley Phillips</u>	
PHYSICIAN'S NAME (Type) <u>Darlington Md</u>		DATE SIGNED <u>5/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/10/59</u>	<u>Memorial Church Cem</u>	<u>East Berken Adams Co Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward P. Baumbach</u>		ADDRESS <u>York, Pa.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



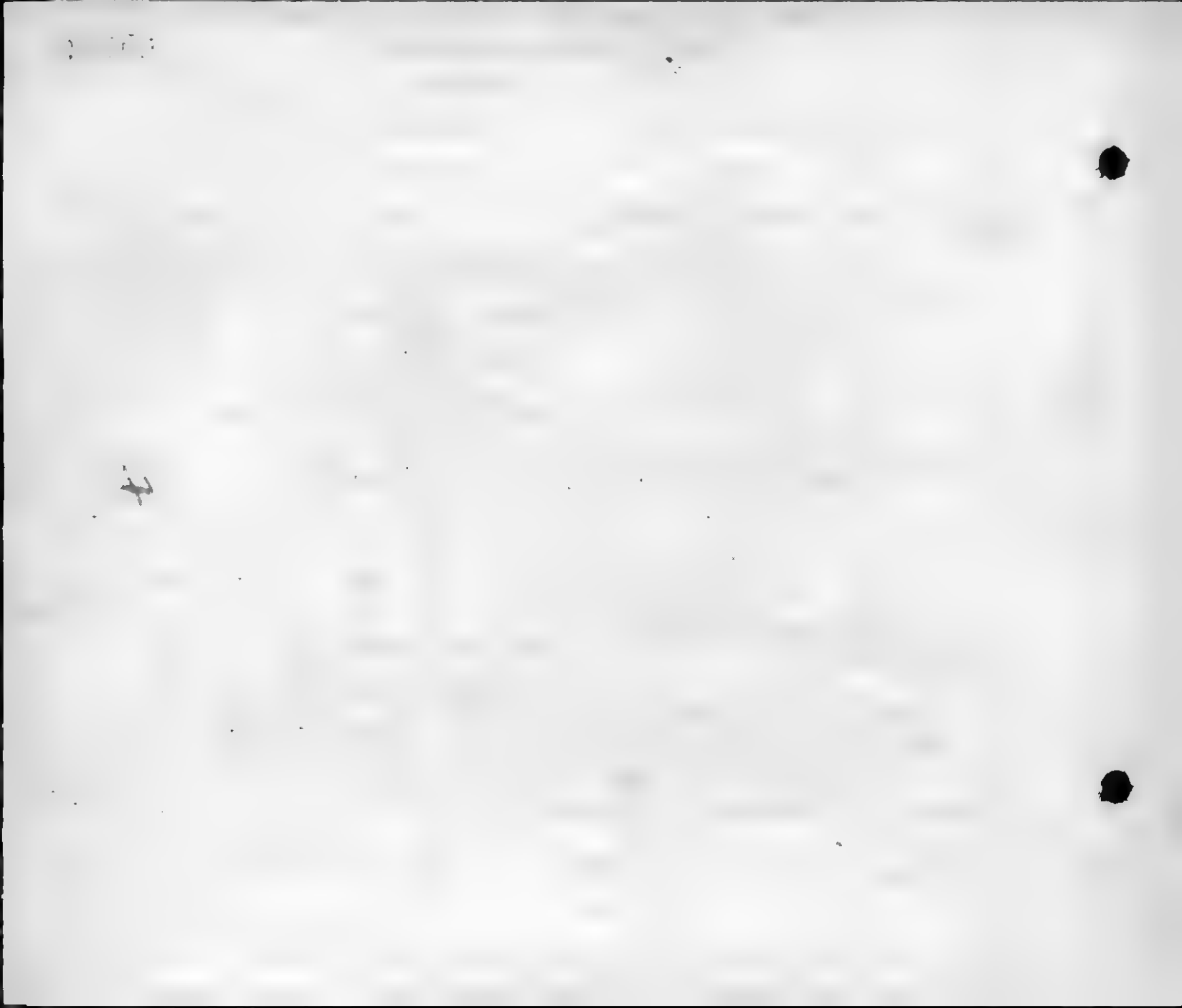
5662 CERTIFICATE OF DEATH

Reg. Dist. No. 05664

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. LENGTH OF STAY IN 1b 6 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Virginia MAE Patrick				4. DATE OF DEATH Month Day Year MAY 19 1959			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 14, 1897	
9. AGE (In years last birthday) 61 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John C. McGraw		14. MOTHER'S MAIDEN NAME NORA Boggs		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 220-14-2928		17. INFORMANT Donnie Patrick Forest Hill, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anteroseptal Infarction 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 5 yrs.		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a m p m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 12th , 19 59 , to May 19 , 19 59 , that I last saw the deceased alive on May 19th , 19 59 , and that death occurred at 1:35 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Foon, M.D.				ADDRESS (Street, city or town, state) 211 N. Union Ave. 5/19/59			
PHYSICIAN'S NAME (Type) Edward C. Foon, M.D.				DATE SIGNED 5/19/59 1 P.M.			
22a. BURIAL, CREMATION, REMOVAL (Specify) May 22, 1959				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY Dublin Cn.				22d. LOCATION (City, town, or county) (State) Harford Co Md			
23. FUNERAL DIRECTOR'S SIGNATURE H. & Bailey Harbington Md				ADDRESS			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE Charles S. Krum			
DATE MAY 22 59							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5663 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harde Chase Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harde Chase</u>	
c. LENGTH OF STAY IN TB <u>20 yrs.</u>		d. STREET ADDRESS <u>900 S. Market</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie Jackson Poist</u>		4. DATE OF DEATH Month <u>5</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/16/1884</u>
9. AGE (In years last birthday) <u>74</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTH PLACE (State or foreign country) <u>Port Deposit, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wesley Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Kora Woodrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Chas. S. Poist</u>		Address <u>900 S. Market St. Harde Chase Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u> <u>YEARS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/14</u> , 19 <u>57</u> , to <u>5/12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/11</u> , 19 <u>59</u> , and that death occurred at <u>11:05 AM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Irwin Randall Ross</u> M.D.		ADDRESS <u>200 N. UNION AVE</u>	
PHYSICIAN'S NAME (Type) <u>IRWIN RANDALL ROSS</u>		ADDRESS <u>HARDE DE GRACE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/15/59</u>		22b. DATE THEREOF <u>Md. Univ</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harde Chase Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Connington Ken, Harde Chase, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

5679

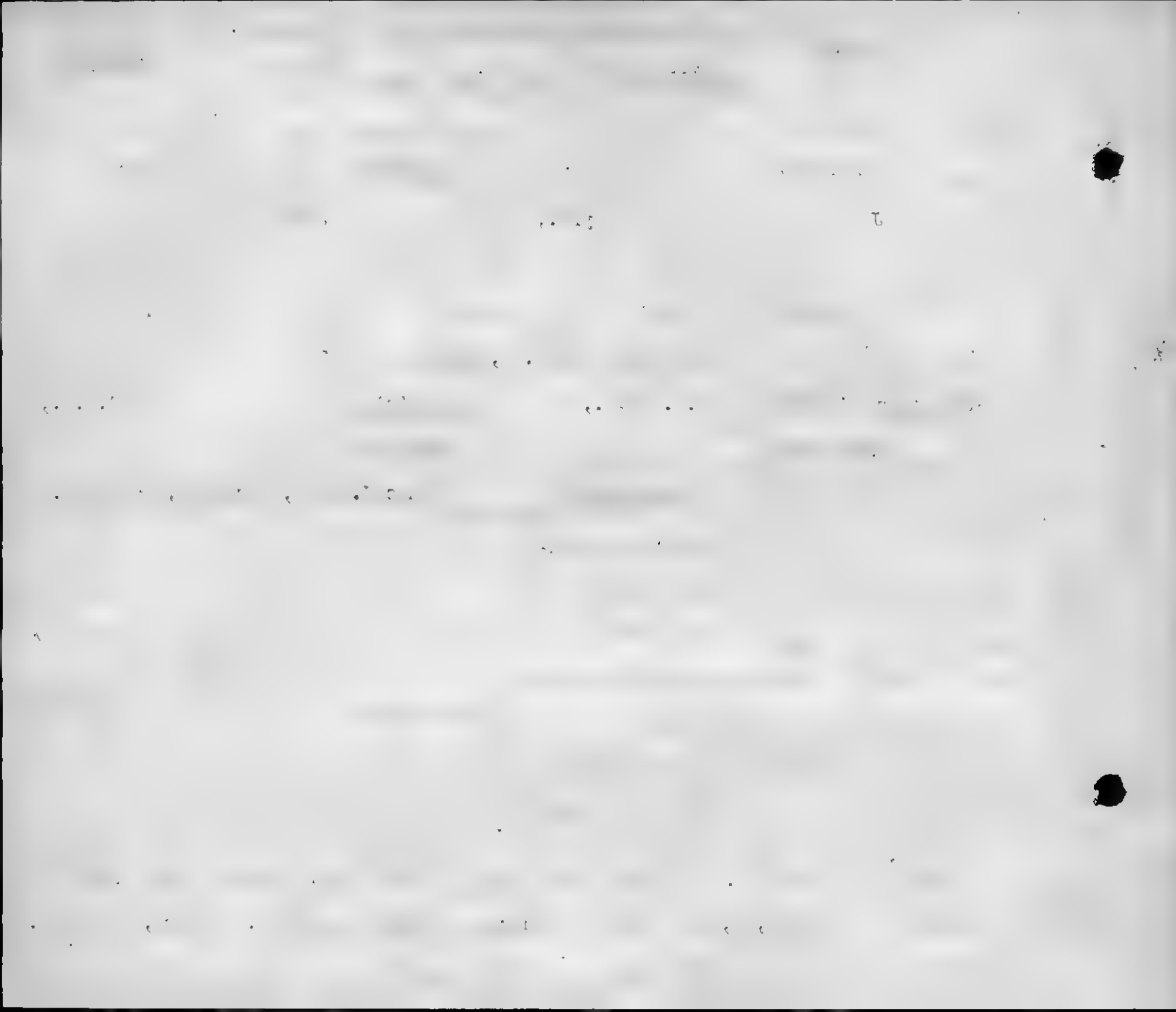
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05666

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppe</u>		LENGTH OF STAY (In this place) <u>10 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppe</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)					
3. NAME OF DECEASED (First) (Middle) (Last) <u>Henry Basye Read</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 21, 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug. 31, 1886</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Thomas Read</u>				14. MOTHER'S MAIDEN NAME <u>Emma Payne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>228-18-4867</u>		17. INFORMANT & ADDRESS <u>Thomas H. Read, Rosedale, Maryland.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Gastric hemorrhage</u>						<u>2 hours</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Carcinoma of the stomach</u>						<u>8 months 7</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 23, 1959</u>, to <u>May 21, 1959</u>, that I last saw the deceased alive on <u>May 20, 1959</u>, and that death occurred at <u>1:12 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>			
DATE SIGNED <u>May 22, 1959</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 24, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs</u>		ADDRESS <u>Alington, Md</u>	
DATE <u>MAY 26 '59</u>							



5664 CERTIFICATE OF DEATH

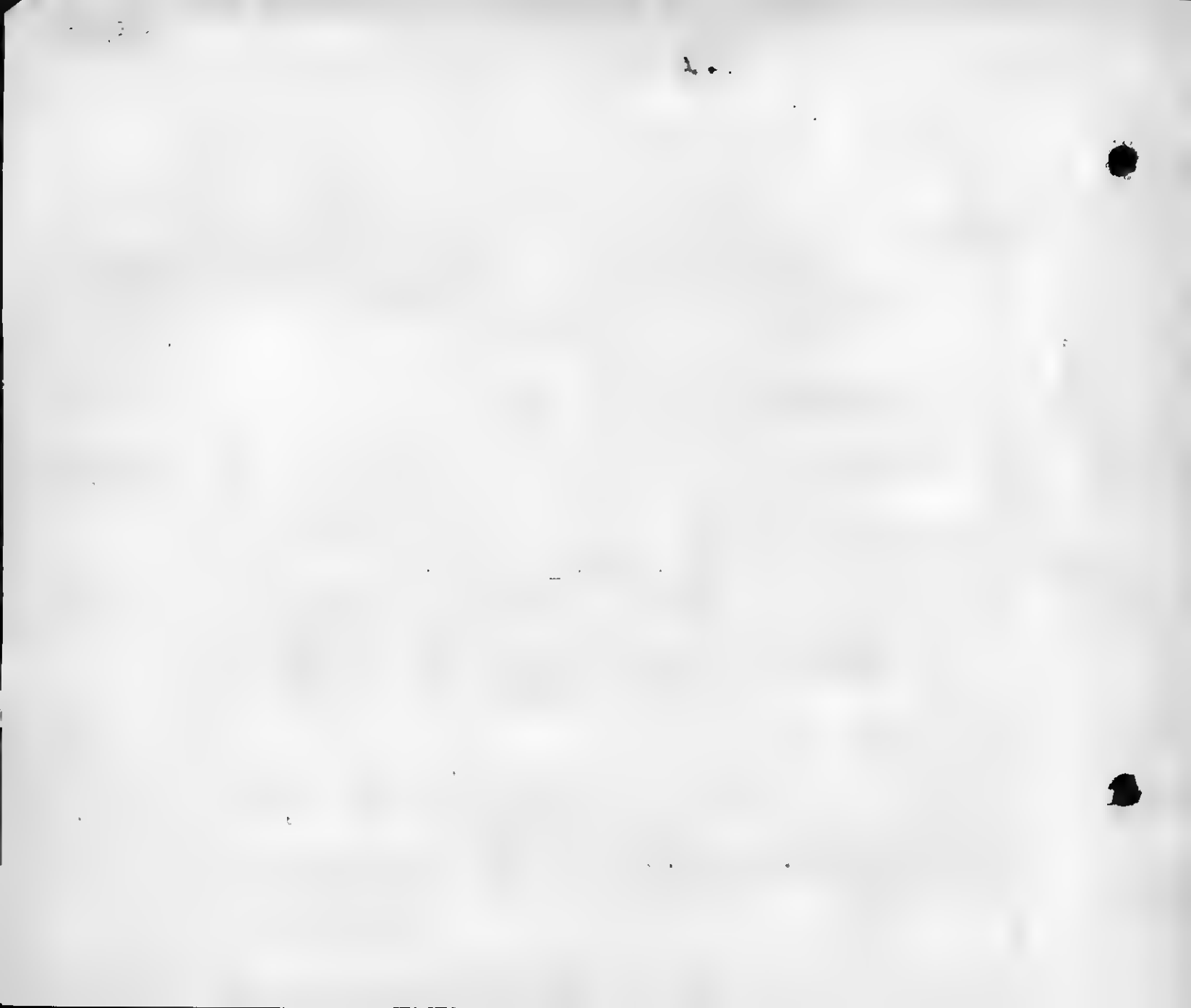
05667

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. LENGTH OF STAY IN <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Forest Hill</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Letcher Alexander Richardson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 28-1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. UNDER 1 YEAR IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Peggy Moxley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Thomas C Richardson</u> Address <u>Bel Air Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>Chronic Cardio-vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 12, 1959</u> , to <u>May 17, 1959</u> , that I last saw the deceased alive on <u>May 17, 1959</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u> DATE SIGNED <u>May 18, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>May 19-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u> ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5665 CERTIFICATE OF DEATH

05668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARVARD GRACE		c. LENGTH OF STAY IN 1b 45 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESAPEAKE DRIVE	
3. NAME OF DECEASED (Type or print) Howard Grant Shafer		4. DATE OF DEATH May 5 1959	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 8, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUSINESS MAN		10b. KIND OF BUSINESS OR INDUSTRY HOME APPLIANCE	
11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES T. SHAFER		14. MOTHER'S MAIDEN NAME CORA WHITMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. 178-10-94411	
17. INFORMANT PEARL M. Shafer - Harvard Grace Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Old rheumatic heart disease and Arteriosclerotic Cardio-vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days 4 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 8th 1954 , to May 5th 1959 , that I last saw the deceased alive on May 5th 1959 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Harvard Grace, Md.			
ACTUAL SIGNATURE Edward C. Toohey, M.D.		DATE SIGNED 5/5/59	
PHYSICIAN'S NAME (Type) Edward C. Toohey, M.D.		at 11:30 AM	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-8-1959	22c. NAME OF CEMETERY OR CREMATORY BELAIR MEMORIAL GARDEN - HARFORD Co.	22d. LOCATION (City, town, or county) (State) MD
23. FUNERAL DIRECTOR'S SIGNATURE William Mitchell		ADDRESS Harvard Grace, Md.	
24a. REC'D BY REGISTRAR DATE MAY 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5680 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
c. LENGTH OF STAY IN 1b <u>6 months</u>		d. STREET ADDRESS <u>7 Grant Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u> <u>Aberdeen Proving Ground, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SUZAN</u> Middle <u>DANIESE</u> Last <u>SHAFFER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 15, 1958</u>
9. AGE (In years lost birthday) yrs. <u>6</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>6</u> Days <u>10</u> Hours <u>19</u> Min <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Joseph Shaffer</u>		14. MOTHER'S MAIDEN NAME <u>Georgenia Erickson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>7 Grant Street</u>	
17. INFORMANT <u>Mother</u>		Address <u>Aberdeen, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased intracranial pressure.</u>		INTERVAL BETWEEN ONSET AND DEATH
752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital hydrocephalus.</u>		
(c)		

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.	Month <u>May</u> Day <u>10</u> Year <u>1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>USAH, APG, Md.</u>
20f. (City or town) <u>Busti, Phantagore Co.</u>		(County) (State)	

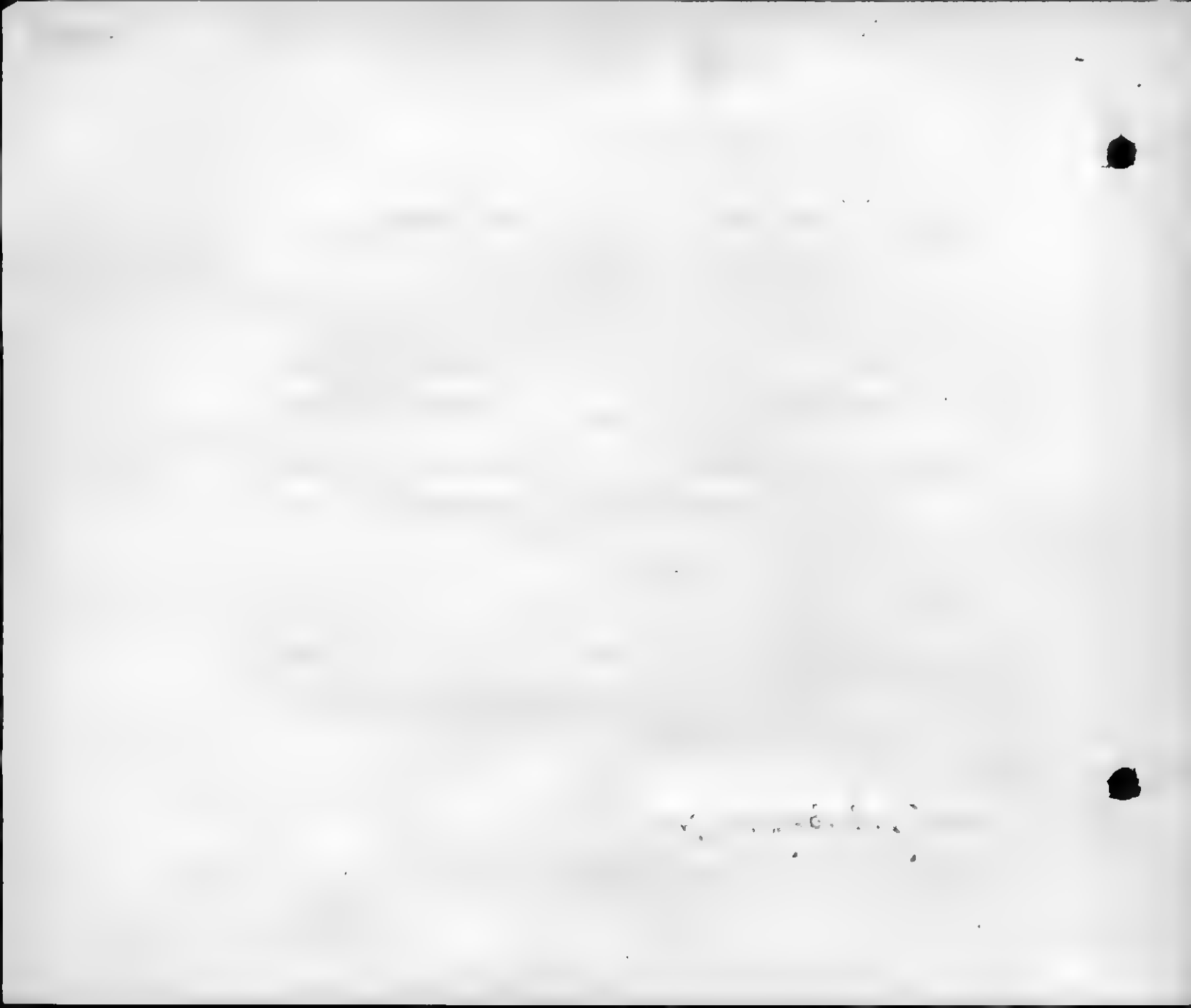
21. I certify that I attended the deceased from May 9 1959, to May 10 1959, that I last saw the deceased alive on May 10 1959, and that death occurred at 6 A M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) Busti, Phantagore Co.
DATE SIGNED 5/11/59
ACTUAL SIGNATURE J. B. Bryant, Jr. M.D.
PHYSICIAN'S NAME (Type) J. B. BRYANT, JR., MAJOR, MC USAH, APG, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>5/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Busti Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Phantagore Co. New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Sarring Aberdeen Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5681

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05670

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P.O. Box #171</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>P.O. Box #171</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Kristie Lynn Shivers</u> First Middle Last 4. DATE OF DEATH <u>May 27</u> Month Day Year <u>19 59</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>E</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan 10, 1959</u> 9. AGE (in years last birthday) <u>—</u> yrs. <u>4</u> Months <u>11</u> Days <u>—</u> Hours <u>—</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u> 11. BIRTHPLACE (State or foreign country) <u>Kansas</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Frank Allan Shivers</u> 14. MOTHER'S MAIDEN NAME <u>Elsie Marie Murray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO <u>—</u> 17. INFORMANT <u>Father: P.O. Box 171 Aberdeen, Md.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o m p m <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerold C Palmer</u> EXAMINER'S NAME (Type) <u>Gerold C Palmer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be/Atin - M</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or MOVING (Specify) <u>Burial</u> 22b. DATE THEREOF <u>5/29/1959</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Sarring</u> ADDRESS <u>Aberdeen Md.</u> 24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> DATE <u>JUN 1 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



5682

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05671

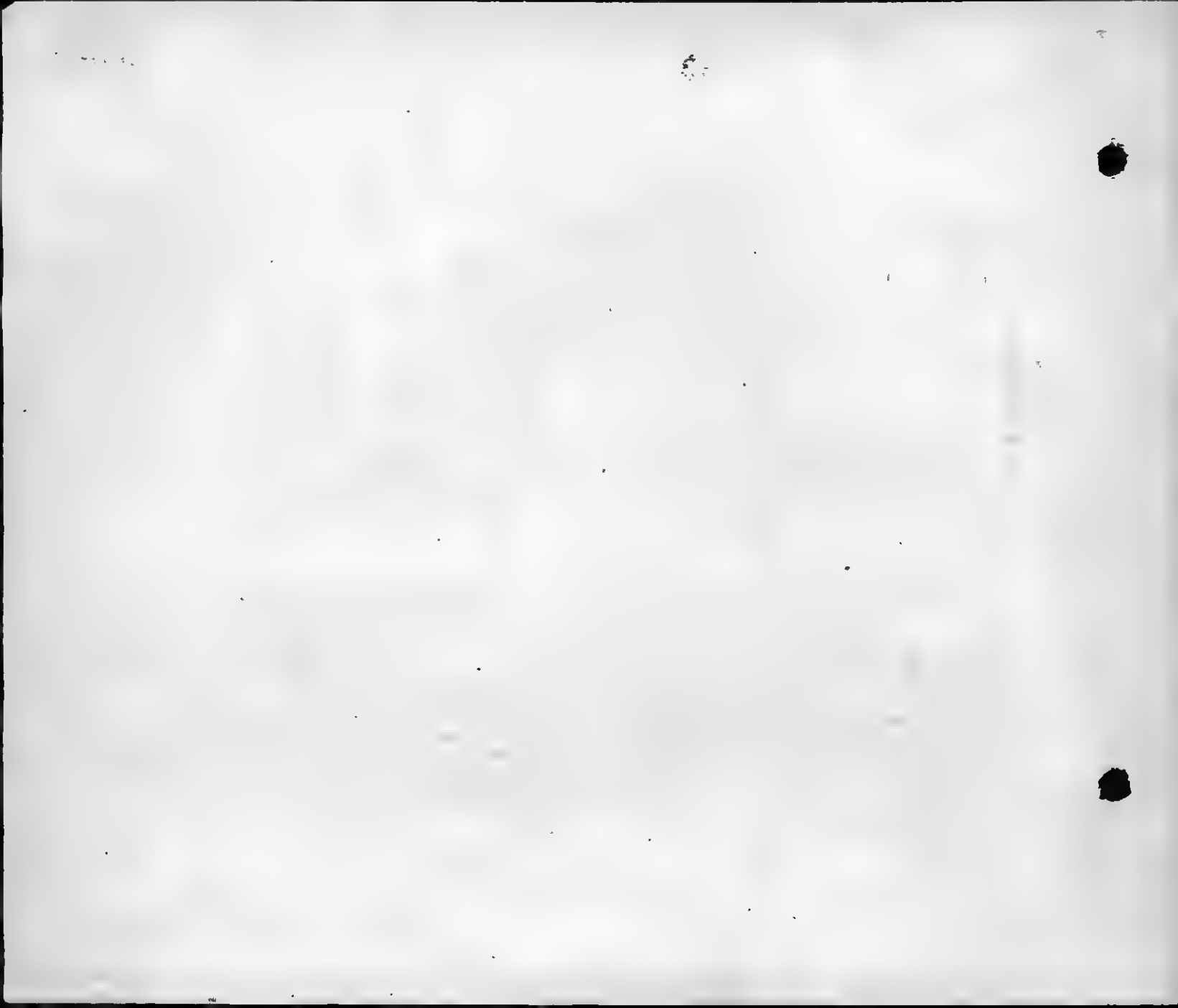
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>US Route 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Donald Franklin Smith</u>		4. DATE OF DEATH <u>May 23 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 18 1933</u>
9. AGE (Years last birthday) <u>25</u> yrs		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>23</u> Hours <u>59</u> Min.	11. IF UNDER 24 HRS Months <u>5</u> Days <u>23</u> Hours <u>59</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Test Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aberdeen Pk.</u>	
11. BIRTHPLACE (State or foreign country) <u>Scotborough Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Verion F Smith</u>		14. MOTHER'S MAIDEN NAME <u>Beulah Cullum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes Navy</u>		16. SOCIAL SECURITY NO. <u>312-32-624</u>	
17. INFORMANT <u>Anna Lee Smith</u>		Address <u>Street Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Cervical Vertebra</u> 815X DUE TO (b) <u>Fracture L. femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Auto accident, auto motorcycle type</u>	
20c. TIME OF INJURY Month, Day, Year <u>5-23-59</u> Hour <u>1</u> p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <u>US Route 1</u>		20f. (City or town) <u>Balton</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <u>Bertin</u> DATE SIGNED <u>5-23-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/26/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Southern</u>		22d. LOCATION (City, town, or county) <u>Doublin Harford Md.</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Furtz</u>		24a. REC'D BY REGISTRAR <u>May 26 1959</u>	
ADDRESS <u>Jarrettsville Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Furtz</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS AISC 1-55 10M

5666

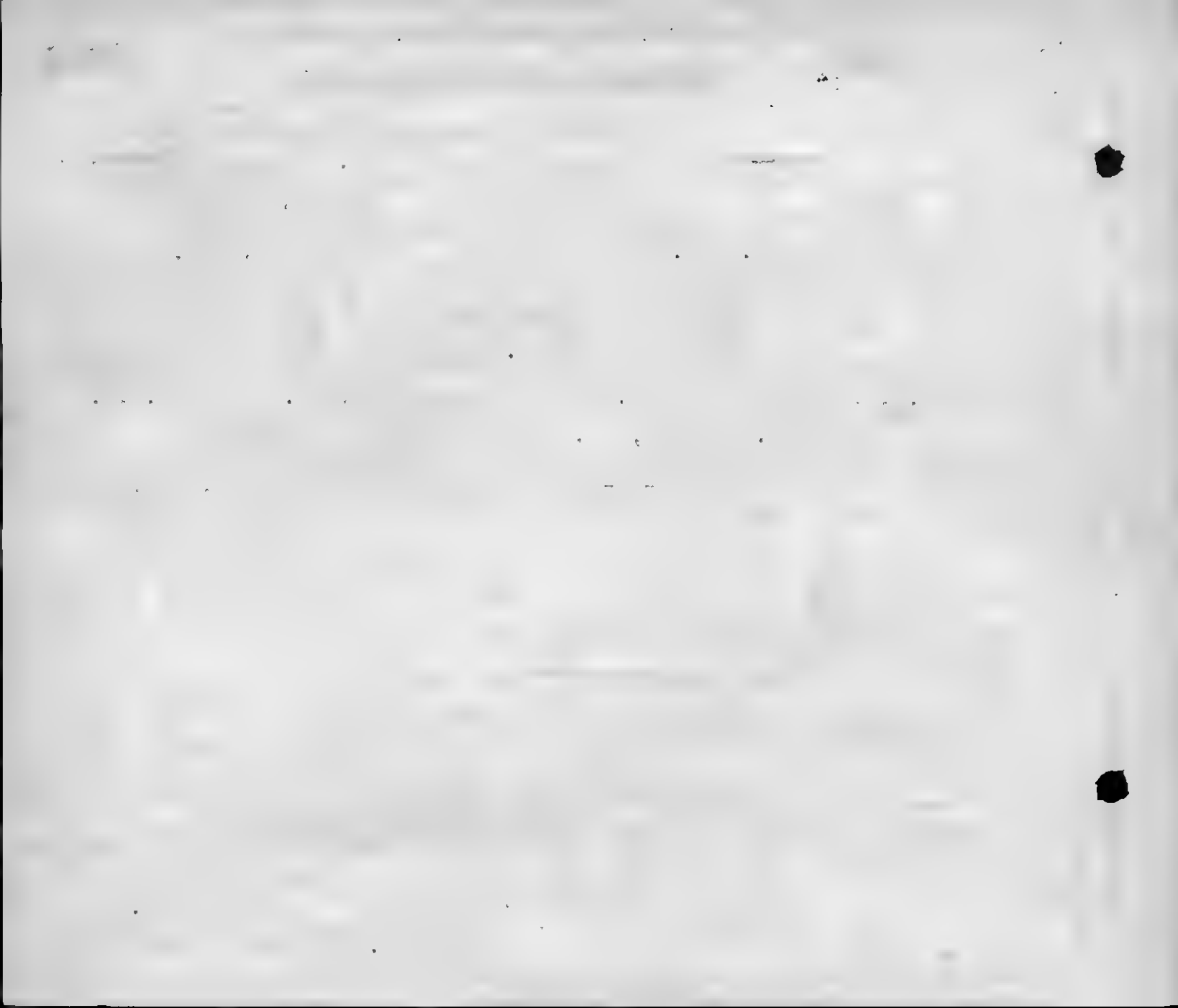
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05672

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY OR TOWN <u>Bel Air</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>206 Penna. Ave.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u> CITY OR TOWN <u>Bel Air</u> STREET ADDRESS <u>206 Penna. Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>CHARLES Ryland STEVENS Jr.</u>				4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>8</u> (Year) <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 6, 1932</u>	9. AGE last birthday <u>26</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>I.B.M. operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glen L. Martin</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles R. Stevens, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Laura Maria Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-30-6217</u>		17. INFORMANT & ADDRESS <u>Maria Harla Stevens, wife, above</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A) <u>Aspiration from Aspiration</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u>	
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Chronic Glomerular Nephritis</u>						<u>10 YEARS</u>	
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/10, 1958</u> , to <u>5/18, 1959</u> , that I last saw the deceased alive on <u>4/16, 1959</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert Barthel</u>				ADDRESS (Street, city, town, state) <u>FOREST HILL MARYLAND</u>		DATE SIGNED <u>5/6/59</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/12/59</u>		NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>		REGISTRAR'S SIGNATURE <u>Charles E. Schimunek</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek Funeral Home</u> ADDRESS <u>3331 Brehms Lane</u>			

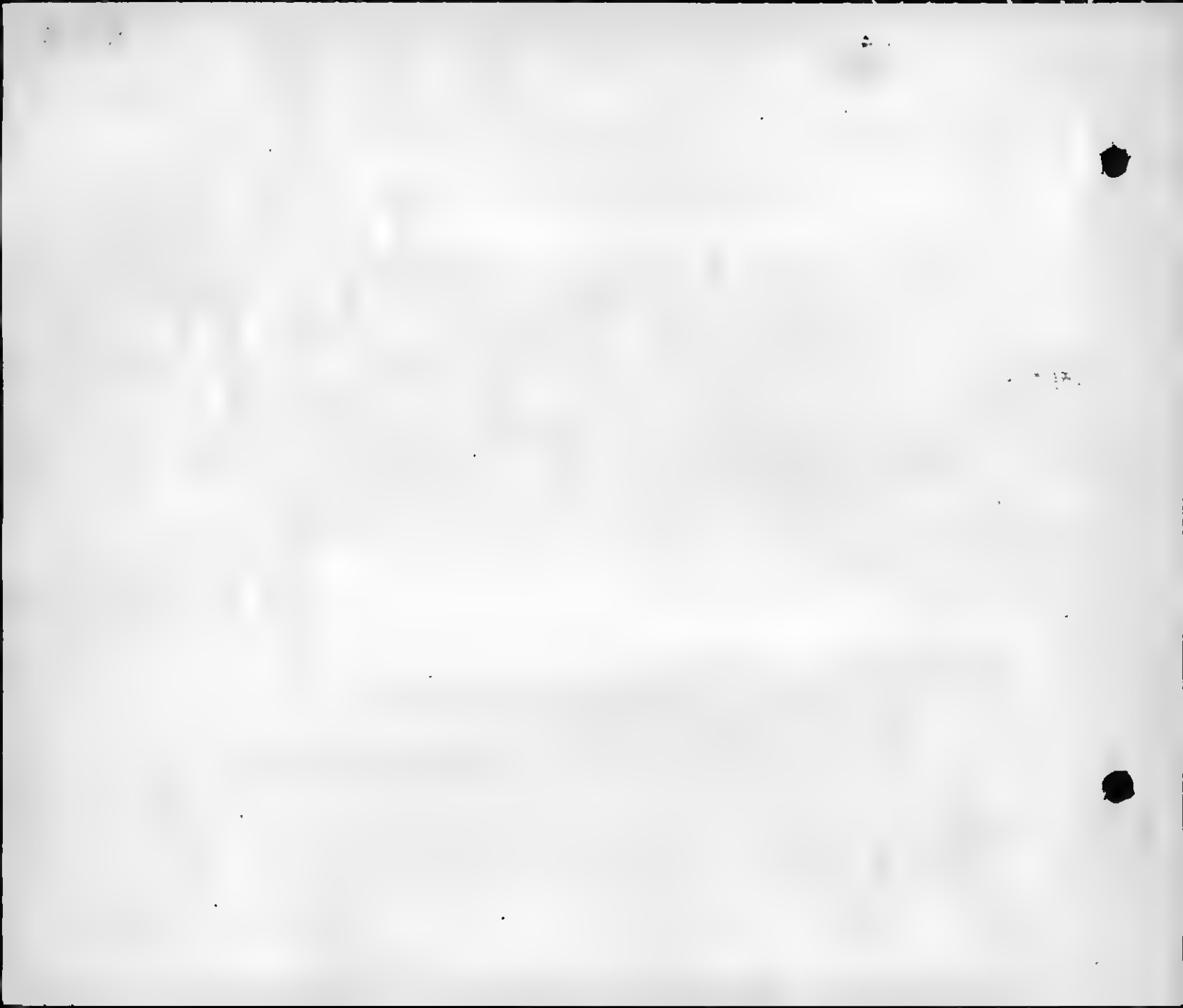


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												05673	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
Item 9, Film G-242, 5-7-59 md													
Reg. Dist. No.													
1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN TB <u>1 1/2 hr</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u> d. STREET ADDRESS <u>Forest Hill</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Israel</u> Middle <u>Taylor</u> Last				4. DATE OF DEATH <u>MAY</u> Month <u>2</u> Day <u>1959</u> Year									
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 16-1879</u>		9. AGE (In years last birthday) <u>80</u>		10. IF UNDER 1 YEAR Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STREET, MD</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>					
13. FATHER'S NAME <u>RICHARD TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA SCARFF</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO				17. INFORMANT <u>MILDRED T. BAILEY</u> Address <u>Forest Hill, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 81dax DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>81dax</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident, auto-pedestrian type</u>									
20c. TIME OF INJURY Month, Day, Year <u>5-2-59</u> Hour <u>2</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>					
				20f. (City or town) <u>Harford</u> (County) <u>MD.</u> (State)									
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>				DATE SIGNED <u>5-2-59</u>					
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>MAY 5, 1959</u>				22c. NAME OF CEMETERY OR CREMATORY <u>HIGHLAND CEM.</u>					
22d. LOCATION (City, town, or county) <u>STREET</u>				(State) <u>MD.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkin</u>				ADDRESS <u>Delta, Pa.</u>				24a. REC'D BY REGISTRAR <u>MAY 5 '59</u>					
								24b. REGISTRAR'S SIGNATURE <u>Arthur E. Harkin</u>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05674

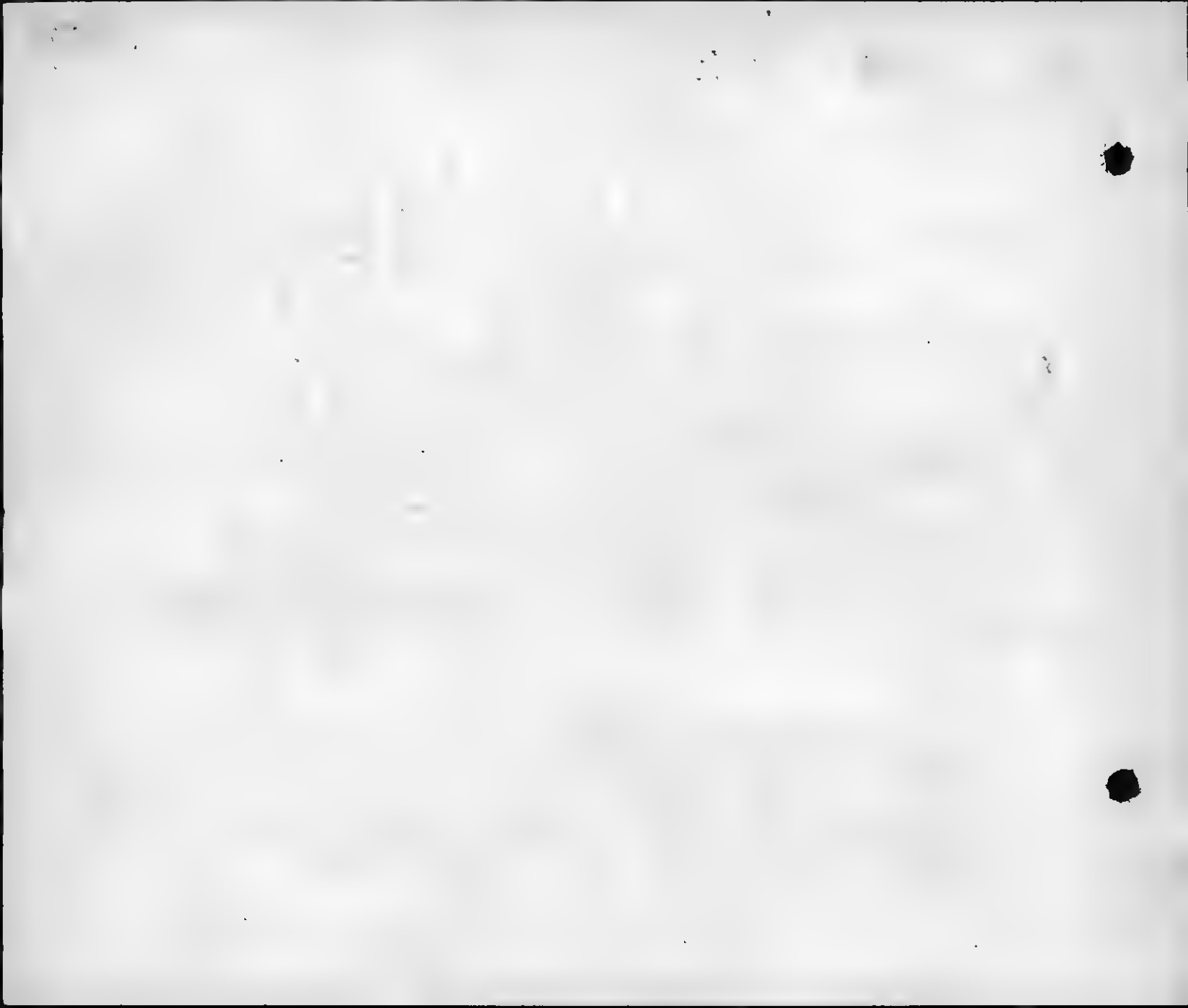
5668

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Give Page 3 to the funeral director. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kalmar</u>		d. STREET ADDRESS <u>1 Kalmar</u>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>A</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23/1917</u>
9. AGE (in years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deputy Sheriff</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co. Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elwood Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Bearl Self</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no) <u>No</u>		16. SOCIAL SECURITY NO <u>218-09-9654</u>	
17. INFORMANT <u>Mrs. Howard Thompson</u>		Address <u>Bel Air, Md. R. 10.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>May 18, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Barlington Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24a. REC'D BY REGISTRAR <u>May 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>C. S. Smith</u>



5683 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KAREN Middle MARIE Last THYNG		4. DATE OF DEATH Month May Day 4 Year 1959	
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 May 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	9. AGE (In years last birthday) yrs 1 Months 1 Days 1 Hours 1 Min 1
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Raymond Boyd Thynge		14. MOTHER'S MAIDEN NAME Vera Marie Disler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO N/A	
17. INFORMANT Father		Address Site B-4 Post Trailer Park Aberdeen, Maryland	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Prematurity**

INTERVAL BETWEEN ONSET AND DEATH

CONDITIONS, if any, which gave rise to immediate cause (c), stating the underlying cause lost.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. **19**
p. m.20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from **May 3**, 19**59**, to **May 4**, 19**59**, that I last saw the deceased alive on **May 3**, 19**59**, and that death occurred at **2:35 AM**, from the causes and on the date stated above.

ACTUAL SIGNATURE

John Z Delp

M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

4 May 59

PHYSICIAN'S NAME (Type)

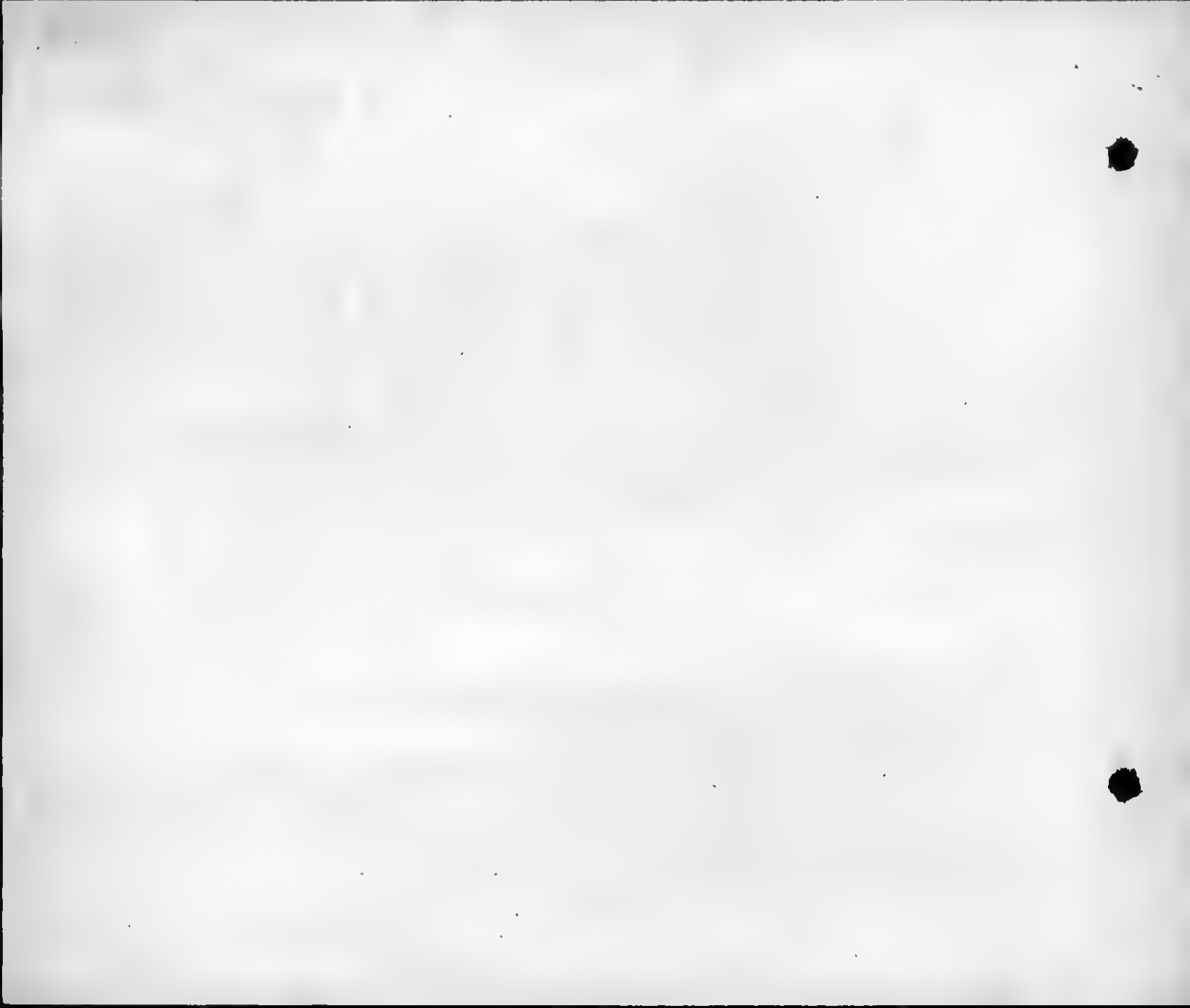
JOHN Z DELP CAPT MC**USAH, APG, Md.**

22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	5/7/1959	Post Cemetery	Aberdeen Proving Ground
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>John F. Darrington</i>		<i>Aberdeen Maryland</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE MAY 8 '59		<i>Arthur L. Thomas</i>	

2050192 Xv1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5684

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural-Bel Air</u>		LENGTH OF STAY (in this place) <u>45 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural-Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Churchville Road</u>				STREET ADDRESS (If rural give location) <u>Churchville Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Betty</u> (First) <u>Young</u> (Middle) <u>Umbarger</u> (Last)				4. DATE (Month) (Day) (Year) DEATH <u>MAY</u> <u>28</u> <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>August 27, 1875</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Young</u>				14. MOTHER'S MAIDEN NAME <u>Francis Kirby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-36-1284</u>		17. INFORMANT & ADDRESS <u>Joseph Y. Umbarger, Bel Air, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebro-vascular accident (thrombosis)</u>						<u>24 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular disease</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>URINARY infection; cardiac failure, compensat</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 18</u> , 19 <u>59</u> , to <u>May 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 28</u> , 19 <u>59</u> , and that death occurred at <u>10:50</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Paul S. Howard</u>		M.D. <u>115 Fulford Ave, Bel Air</u>		DATE SIGNED <u>5/28/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>May 31, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Methodist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fountain Green, Maryland</u>	
24. REC'D BY REGISTRAR <u>JUN 2 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway + Williams St. Bel Air, Maryland</u>			

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



5669 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
c. LENGTH OF STAY IN IB <u>D.O.A.</u>		d. STREET ADDRESS <u>14 Rigdon Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>VACIK</u> Last <u>VACIK</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-29-04</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>	IF UNDER 24 HRS. Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fire-man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.P.S.</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Vacik</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Mikolalik</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Novak Funeral Home - 5513 Brighton Rd</u>		17. INFORMANT Address <u>Pittsburgh Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>30 MIN</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY 27, 1959</u> to <u>MAY 27, 1959</u> , that I last saw the deceased alive on <u>MAY 27, 1959</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip W. Human</u> M.D.		ADDRESS (Street, city or town, state) <u>307 Hickory</u> DATE SIGNED <u>MAY 27, 59</u>	
PHYSICIAN'S NAME (Type) <u>Philip W. Human</u>		<u>BEL AIR, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>5/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Highwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pittsburg, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Garrison</u> ADDRESS <u>Aberdeen, Maryland</u>		24. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5670 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>9 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John B VETTORINO</u>				4. DATE OF DEATH Month Day Year <u>MAY 22 19 59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 3-1878</u>	
9. AGE (In years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Barber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Anthony VETTORINO</u>				14. MOTHER'S MAIDEN NAME <u>MARIA CAPITELLI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>John B Vettorino</u>				Address <u>305 D. Augusta St. Annapolis Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 757.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Surgery for Polycystic Disease of Kidney</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 15 19 57</u> to <u>May 22 19 57</u> , that I last saw the deceased alive on <u>May 21 19 57</u> , and that death occurred at <u>5 15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Doris J. Bryant</u>				DATE SIGNED <u>610 S Union Ave</u>			
PHYSICIAN'S NAME (Type) <u>John B Vettorino</u>							
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5/26/59</u>		<u>St. Johns</u>		<u>Woodhams R.D. N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>VIGLIANTE FUNERAL HOME</u>				24a. REC'D BY REGISTRAR <u>406 ROGERS AVE</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5030

State of Maryland

Form with multiple sections for recording death information, including fields for name, date, place, and cause of death. The form is filled out with handwritten text.

DECEASED
Name: John Doe
Age: 45
Sex: Male
Race: White
Date of Birth: 10-15-1910
Place of Birth: Washington, D.C.
Date of Death: 11-10-1955
Place of Death: Home
Cause of Death: Heart Disease
Occupation: Teacher
Signature: [Signature]
Registrar: [Signature]

Vertical text on the right margin, likely a filing or archival note.